**Physical Exam Form C**

Manchester Health Department
1528 Elm Street
Manchester NH 03101
Tel: (603) 624-6466 Fax: (603) 624-6584

School Name: _____
Grade: ___
School Fax: _____

***Instructions to Parent***: In order to best meet your child's educational and health needs in the school setting we need background information relating to the child's current health status. Please have your medical provider fill out this form and return it to the school. **Physician/Provider may complete his/her own physical exam form.**

Name: _____DOB: _____

Height: _____ Weight: _____ BMI: _____ Ref: Yes / No _____

Scoliosis: Screen: _____ Ref: Yes / No _____ B/P: _____Ref: Yes / No _____

**HEALTH ASSESSMENT**:

| Complete each line | Normal | Abnormal | Needs Follow-Up | Not Examined |
|---|---|---|---|---|
| Lead Level | | | | |
| Vision / Right | | | | |
| Vision / Left | | | | |
| Hearing / Right | | | | |
| Hearing / Left | | | | |
| Skin/Scalp | | | | |
| Nutrition | | | | |
| Neurological & Muscular | | | | |
| Spine & Extremities | | | | |
| Eyes | | | | |
| Ears | | | | |
| Nose, Throat, Mouth | | | | |
| Glands (including Thyroid) | | | | |
| Chest, Breasts | | | | |
| Heart, Lungs | | | | |
| Abdomen | | | | |
| Genitalia | | | | |

A. Any chronic illness that may require medication or special accommodations in school (e.g. seizure disorder, food, allergies, asthma)? (*Medication taken during school hours, requires a written physician's order)*

B. Pertinent past family/medical history

C. Developmental/Psychosocial /Emotional Assessment:

D. Updates in Immunizations Boosters given:
**Attach updated Immunization Record**

The above named patient has been determined to be in good health and may participate in day care, school, sports, camp with:
**Restrictions:** _____**No restriction**_____ **Date of Exam:** _____

**Licensed Provider's Signature:** _____**Date**_____

**Licensed Provider's Name: (Please print):** _____